UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

XARELTO (rivaroxaban)

Patient Name:_____ Medicaid ID:_____

Prescriber Name:_____ NPI:_____ Phone: _____

Contact Person: _____ Fax:_____

Pharmacy Name:_____ NPI:_____ Phone: _____

Pharmacy Fax:_____ Requested Strength:_____ Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

Initial and Re-Authorization Criteria per Indication:

- **Reduction in Risk of Stroke in Nonvalvular Atrial Fibrillation:**
  - 20mg daily if creatinine clearance > $50^{mL}/_{min}$
  - 15mg daily if creatinine clearance is between $15^{mL}/_{min}$ and $50^{mL}/_{min}$
  - Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity

- **Prophylaxis of DVT following Hip or Knee Replacement:**
  - 10mg daily for 35 days following hip replacement
  - 10mg daily for 12 days following knee replacement
  - Extended treatment beyond the limited days following hip or knee surgery will not be authorized for the same surgical event. Treatment for subsequent procedures may be given upon receipt of a new prior authorization request.

- **Treatment of DVT or PE:**
  - 30mg daily (15mg BID) for 21 days…..*THEN*…..20mg daily
  - Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity

- **Prevention of Recurrence of DVT or PE:**
  - 20mg daily
  - Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity